Clermont County 2011 New Hire Benefit Election/Change Form

☐ **New Hire: Full time date of hire** ___________________

☐ **Part-Time to Full-time: Original date of hire** __________________________ **Full-Time date**__________________________

☐ **Change** *(documentation required)*: **Qualifying event**____ **Qualifying Event Date**____________________

EMPLOYEE INFORMATION

Clock #:	Dept #:	Dept Name:	Work Phone:	Home Phone:	☐ Male ☐ Female	If married, is spouse a Clermont County employee?
Last Name:	First Name:	SS#:	Date of Birth:			
Address:	Apt:	City:	State:	Zip:	☐ Single ☐ Married	☐ Y ☐ N

ELECTION INFORMATION *(deductions are 2x per month)*

Health Care Plan Choices / Deductions			Voluntary Life Insurance *Attach completed life enrollment form*	Flexible Spending Account (FSA) *Attach completed Chard-Snyder Form*	Health Plan Deduction Totals: *(Enter per pay totals below)*
Medical: *(choose one)* **NPOS1:** ☐ Single $38.09 ☐ Family $160.42 **NPOS2:** ☐ Single $19.20 ☐ Family $107.52 **WAIVE** ☐	**Dental:** ☐ Single $13.28 ☐ Family $36.50 ☐ Waive	**Vision:** ☐ Single $2.97 ☐ Family $7.49 ☐ Waive	**Amount of Coverage:** **Per Pay:** **Employee:** $__________ $_________ **Spouse:** $__________ $_________ **Child(ren):** $__________ $_________ **Up to $110,000 w/o medical form – emp.* **Up to $50,000 w/o medical form-spouse* **Up to $20,000 (max 50% of emp.amt)-child*	**HealthCare:** **Annual Election:** **Per Pay*:** $_________________ $___________ **Dependent Day Care:** **Annual Election:** **Per Pay*:** $_________________ $___________ ******Divide your annual election by the number of months left in the year, then divide by 2 to get your per pay deduction.*	**Medical:** $___________ **Dental:** $___________ **Vision:** $___________ **Emp. Life:** $___________ **Spouse Life:** $___________ **Child Life:** $___________ **FSA Health:** $___________ **FSA Daycare:** $___________
				TOTAL:	

ELIGIBLE DEPENDENTS

Dependent Name (First, Last)	Spouse / Child	Male / Female	Date Of Birth	Social Security #	Medical Add/Del	Dental Add/Del	Vision Add/Del	Disabled	FT Student age 19-25	Other Coverage? Type? *Please attach plan information*
	☐ S ☐ C	☐ M ☐ F						☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	☐ S ☐ C	☐ M ☐ F						☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	☐ S ☐ C	☐ M ☐ F						☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	☐ S ☐ C	☐ M ☐ F						☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
	☐ S ☐ C	☐ M ☐ F						☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

EMPLOYEE: I certify that the information provided on this form is true & accurate. I understand that my elections will remain in effect through December 31st of each year & acknowledge that I cannot make any changes to my elections during the plan year unless I experience a qualifying event. I authorize Clermont County to take the corresponding payroll deductions for the benefits I have elected.

Employee Signature:__________________________________ **Date:**_____________________

PAYROLL DEPT:	Single Plan	Family Plan
County Contribution:	$172.81	$430.09
NPOS 1 Emp. Ded:	$38.09	$160.42
NPOS 1 Actual Cost:	$210.90	$590.51
County Contribution:	$172.81	$430.09
NPOS 2 Emp. Ded:	$19.20	$107.52
NPOS 2 Actual Cost:	$192.01	$537.61

HR USE ONLY